1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removol, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01779 — 01802

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: BELTON | Middle: DANIEL | Lost: BANKS | 2a. DATE OF DEATH KNOWN XX ESTIMATED ☐ | Month: Doy: 1-8-70 | Year: 19 | 2b. HOUR: 7:30 P M |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: 5-28-65 | 6. AGE (In years last birthday): 4 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month Jan. Doy 8 Year 1970 | 2d. HOUR: ? M |
| 7a. BIRTHPLACE (State or foreign country): Newark | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: WORCESTER Md. | | | | |
| 10. CITY OR TOWN OF DEATH: RFD Snow Hill | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Basket Switch Road | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Basket Switch Rd. | | | |
| 14. FATHER'S NAME: First Unknown | Middle | Lost | 15. MOTHER'S MAIDEN NAME: First Mary | Middle Banks | Lost | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mary Banks | ADDRESS: Rt #1 Box 89 Newark Md. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon monoxide intoxication — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b): Conflagration
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if ony, which gove rise to immediote couse (a). stoting the underlying couse lost.
890.X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES XX NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY XX OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Year: HOUR XX 7:30 P.M. 1-8 19 70 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.): Trapped in burning house |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.): Home | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Basket Switch Rd, Snow Hill, Worcester, Md. |

22a. **I certify** thot I took chorge of the remoins described obove, held on Autopsy ☒, Inspection ☐, Inquiry ☐, ond in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)
22b. DATE SIGNED: 1-10-70

| 23a. BURIAL, CREMATION REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1-17-70 | New Bethel | Berlin Worc. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Jolley Memorial Chapel | Salisbury Md. | JAN 19 1970 | J. Charles Judge |

VR A15ME (5) 10M REV. 1/68

1

**FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05006

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First (Sorita) | Middle | Last Mary Screta Banks | | | | | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ | Month 1/8 | Day | Year 1970 | 2b. HOUR M |
| 3. SEX F | 4. RACE N | 5. DATE OF BIRTH 4/6/66 | 6. AGE (In years last birthday) 3 YRS. | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month | Day | Year 19 | | 2d. HOUR M |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH Worcester Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Newark, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Worcester | 13c. CITY OR TOWN Newark | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER Basket Switch Road | | | | | | | | |
| 14. FATHER'S NAME First Unknown | Middle | Last | 15. MOTHER'S MAIDEN NAME First Mary Esther Banks | Middle | Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. none | 17. INFORMANT Mary Esther Banks | ADDRESS Newark, Md. | | | | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Burns, 4th degree, entire body — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: instant

890X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 7:30 1/8/70 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) House fire |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

By orddrof the Circuit Court, Wor.Co

22a. **I certify** that I took charge of the remoins described above, held an Autapsy ☐, Inspectian ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 3/10/70

EXAMINER'S NAME (Type) Francis J. Townsend, Jr., M.D. ADDRESS (Street, city, town, or county) Ocean City, Md. Wor. County

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | CHILD'S BODY COMPLETELY CONSUMED BY FIRE Film G423 4/21/70 jcp | | |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE MAR 18 1970 | 25b. REGISTRAR'S SIGNATURE Charles Judge |
|---|---|---|
| | | |

VR A15ME (5)
10M - 1/69

1

01780

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

01803

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Lula | Mary | Barnes | Jan. 17 1970 | 9 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | July 20, 1884 | 85 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | WIDOWED ☑ | Worcester Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Girdletree | — | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Girdletree | YES ☑ NO ☐ | — |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| James | Edward | Barnes | Mary | Grace | Stanford |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | — | 220 46 2265 | Mrs. Blanche B. Berdan | Girdletree Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | ACUTE PULMONARY EDEMA | 2 hr |
| DUE TO, OR AS A CONSEQUENCE OF (b) | MYOCARDIAL INSUFFICIENCY | 3 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ARTERIO SCLEROTIC HEART DISEASE | 10 yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

412.3

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from Jan 19 69, to Jan 17 70, that (I) (~~we~~) last saw the deceased alive on Jan 17 1970, and that ~~in~~ (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Robert C. La Mar | | ☑ | ☐ | ☐ | 1-19-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Robert C. La Mar, M.D | 104 Bay St, Snow Hill, Md. 21863 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 20, 1970 | Springhill Meth. | Girdletree, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Norman F. Glenn | Snow Hill, Md. | JAN 23 1970 | J. Charles Judge |

VR A15 (4)
30M REV. 1-68

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

01781 — 01804

1. DECEASED-NAME (Type or print): First: Lessie; Middle: C.; Last: Heath
2a. DATE OF DEATH: Month: Jan; Day: 23; Year: 1970
2b. HOUR: M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 10-30-85
6. AGE (In years last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: Worcester Md.
10. CITY OR TOWN OF DEATH: Stockton
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Holland Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Machine Oper.
12b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Mardela
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER:
14. FATHER'S NAME First: Oliver; Middle: T.; Last: Catline
15. MOTHER'S MAIDEN NAME First: Alexine; Middle: ; Last: Insley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 217-01-4276
17. INFORMANT: Address: Mrs. Alice Baker, Mardela, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE PUL. MONARY EDEMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.4
DUE TO, OR AS A CONSEQUENCE OF (b): MYOCARDIAL FAILURE — 1 wk
DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): LARGE DECUBITUS ULCER ON FOOT & CACHEXIA

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from SEPT, 1969, to JAN 23, 1970, that (I) (~~we~~) last saw the deceased alive on JAN 15 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Robert G La Mar — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 1-24-70
22d. PHYSICIAN'S NAME (Type): Robert G La Mar, M.D.
22e. ADDRESS: 104 Bay St Snow Hill, Md. 21863

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-25-70
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Oak Grove
23d. LOCATION (City or Town) (County) (State): Westerville, Maryland
24. FUNERAL DIRECTOR ADDRESS: Messick F.H., Bivalve, Md. 21814
25a. RECD BY REGISTRAR DATE: JAN 29 1970
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 A
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

01782 — 01805

1

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| KATHERINE | GERTRUDE | KEILY | January 28, 1970 | 5:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | Jan. 8, 1874 | 96 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | U.S.A. | NEVER MARRIED [X] | WORCESTER Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Pocomoke City | 4 Winter Qtrs. Drive | Secretary | General |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Pocomoke | YES [X] NO [ ] | 4 Winter Qtrs. Drive |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Michael | B. | Keily | Katherine | - | Farrell |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | -- | 188-30-6032A | Mrs L. W. Chamberlain, Pocomoke, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF
(b) ASHD
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1965, 19__, to 1970, 19__, that (I) (we) lost saw the deceased alive an ____ 19 70, and thot in (my) (our) opinion death accurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Donald J. Amrien | M.D | [X] | ☐ | ☐ | Feb. 3, 1970 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Donald J. Amrien, M.D | Chincoteague, Va. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1-31-1970 | Presbyterian | Pocomoke City-Wor.-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert N. Watson | Pocomoke City, Md. | FEB 6 1970 | Charles Judge |

Robert N. Watson

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

01783 — 01807

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year |
| ASA | FRANKLIN | PILCHARD | January 18, 1970 |

2b. HOUR: 10:30 P.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | July 5, 1883 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | WIDOWED X | WORCESTER Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Pocomoke City | R.F.D. 3 | Farmer | Farming |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Pocomoke | NO X | R.F.D. 3 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Henry | -- | Pilchard | Susan | -- | Payne |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | -- | 217-36-0710 | Mrs Thelma Burbage | Pocomoke City, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.3
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours / Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): 1d Bronchiectasis, Emphysema, 2. Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from Jan. 1955, to Jan 18 1970, that (I) ~~(we)~~ last saw the deceased alive on Jan. 17 1970 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE Charles W Trader M.D. DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 1-20-70

22d. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D. — 22e. ADDRESS 302 Market St., Pocomoke, MARYLAND.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY ~~OR CREMATORY~~ | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1-21-1970 | Goodwill Methodist | Pocomoke City-Wor.-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Robert N. Watson | Pocomoke City, Md. | JAN 23 1970 | Charles Judge |

Robert N. Watson

VR A15 (4)
30M REV. 1-68

1

**FOR STATE HEALTH DEPT.**

01784

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01808

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Oscar | Middle: | Lost: Powell | 2o. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: Jan. Doy: 23 Year: 1970 | 2b. HOUR: 2:30 P M | | | | |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: July 12, 1922 | 6. AGE (In years last birthday): 47 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month: Jan. Doy: 23 Year: 1970 | 2d. HOUR: 5:45 P M | |
| 7o. BIRTHPLACE (State or foreign country): Fla. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Worcester Md. | | | | | |
| 10. CITY OR TOWN OF DEATH: Pocomoke | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 626 Cedar St. | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Plumber | | | | | |
| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 626 Cedar St. | | | | |
| 14. FATHER'S NAME First: Louis | Middle: | Lost: Powell | 15. MOTHER'S MAIDEN NAME First: Mollie | Middle: | Lost: Gillette | | | |
| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes | 16b. SOCIAL SECURITY NO. (If wife give war or dates of service): WWII 238-20-5576 | 17. INFORMANT: Evelyn Powell | ADDRESS: 626 Cedar St. Pocomoke, Md. | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o): Right Lobar Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

481.x

Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

| | | |
|---|---|---|
| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21o. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote |

22a. **I certify** that I taak charge af the remains described abave, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Jesus G. Santiano M.D.

EXAMINER'S NAME (Type): Jesus G. Santiano, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 1-26-70

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1-31-70 | Dublin Cem. | Princess Anne Somerset Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Samuel Lange | New Church, Va. | JAN 29 1970 | J. Charles Judge |

VR A15ME (5) 10M REV. 1/68

1

01785

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

01809

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| James | Clayton | Smullen | Jan. | 11 | 1970 | 2:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | Feb. 24, 1886 | 83 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Worcester Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Snow Hill | RFD #1 | Well Driver | Water |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Snow Hill | | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Joshua | | Smullen | Martha | | Tarr |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 218349041 | Mrs. Lula Cherrix, Snow Hill Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CACHEXIA + INANITION | 1 Month |
| DUE TO, OR AS A CONSEQUENCE OF (b) | BRONCHIOGENIC CARCINOMA | 6 Mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from SEPT 1, 1969, to JAN 11, 1970, that (I) ~~(we)~~ last saw the deceased alive on JAN. 10 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. ~~(I) (we)~~ ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|
| John La Mar M.D. | | | | 1-13-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| J. La Mar, M.D. | 104 Bay St Snow Hill, Md. 21863 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1-13-70 | Mt. Olive | Snow Hill Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Norman F. Morris, Snow Hill Md. | JAN 16 1970 | Edwards Judge |

VR A15 (4)
30M REV. 1-68

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01786

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01810

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Willie | Middle: | Last: Taylor III | 2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐ | Month: Jan | Day: 27 | Year: 1970 | 2b. HOUR | M |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH: July 1, 1969 | 6. AGE (In years last birthday): YRS. 0 | IF UNDER 1 YEAR MONTHS: 6 | DAYS: 26 | IF UNDER 24 HRS. HOURS: | MIN.: | 2c. DATE PRONOUNCED DEAD Month: Jan. | Day: 27 | Year: 1970 | 2d. HOUR | M |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Worcester | | | | | | | | | Md. |
| 10. CITY OR TOWN OF DEATH: Pocomoke | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 416 Oxford St. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 416 Oxford St. | | | | | | | | |
| 14. FATHER'S NAME First: Willie | Middle: | Last: Taylor Jr. | 15. MOTHER'S MAIDEN NAME First: Jennifer | Middle: | Last: Costen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Jennifer C. Taylor | ADDRESS: Pocomoke, Md. | | | | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pneumonia | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Infection during Bronchitis | 1 day |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

490X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE _____ M.D.

EXAMINER'S NAME (Type): N. E. Sartorius M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county)

22b. **DATE SIGNED**: 1/28/70

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 1-30-70 | St. James Cem. | Pocomoke | Wor. | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD. BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Samuel Lewis | New Church, Va. | JAN 30 1970 | |

VR A15ME (5)
10M REV. 1/68